Minutes of:
State Advisory Committee on Substance Abuse Services
September 17, 2009

9:00AM – 3:00PM
Country Inn/Suites, 5353 North 27th Street, Lincoln, NE

Present (8): Ann Ebsen, Rand Wiese, Randy See, Subhash Bhatia, Laura Richards, Jay Jackson, Corey Brockway, Vicki Maca

Absent (3): Dr. Mercer, Brenda Miner, Linda Krutz

DHHS Staff Present: Jim Harvey, Alexandra Castillo, Christine Newell, Nancy Heller
Alexandra Castillo is now assigned to be the HHS support staff for this committee.

Guests Present: Judie Moorehouse, Joshua Robinson, Otto Schulz, and Linda Wittmuss

Welcome/Introductions
Chairperson Ann Ebsen called the meeting to order at 9:03 a.m. Committee members briefly introduced themselves.

Attendance – Determination of Quorum
Roll call taken by Christine Newell. At least seven members were present constituting a quorum.

Approval of July 14 , 2009 Minutes
Motion made by Rand Wiese to approve minutes, seconded by Laura Richards. Motion adopted by unanimous voice vote.

Approval of Agenda
Motion made by Randy See to approve the day's agenda, seconded by Corey Brockway. Motion adopted by unanimous voice vote.

Future Meeting Dates
Attachment A
2010 SACSAS Meeting Dates were proposed to the committee and Jim Harvey explained the Division proposes a Mental Health and Substance Abuse joint day long meeting on May 6, 2009 to discuss Co-Occurring Disorders. The Committee requested there be a breakout time for the SA committee to take care of business and it was suggested the best time for break out time would be at 9:00 am.

Motion made by Corey Brockway to support the Co-Occurring Disorders meeting on May 6, 2010, seconded by Dr. Bhatia. Motion adopted by unanimous voice vote.

The new meeting dates for 2010 are:
February 2, 2010, May 6, 2010, September 21, 2010 and December 7, 2010.

Public Comment
Chairperson Ann Ebsen asked for public comment. No public comment.

Division Reports
Recovery Month – Overview of Activities - Rand Wiese
Rand Wiese, Event Specialist with the Nebraska Recovery Network, stated that September is Recovery month. There was a lot of activity through out the state and regions. Media announcements via TV and the Lincoln Journal Star were great. There were full page ads about Methamphetamine Addiction. On September 13, 2009, there were about 400 people on the capital steps. Kids were involved with "It's not your fault that mom and dad have a problem." Work for next year's rally has already started. The plan for next year is to get more people involved, and get more snacks and beverages.

Dr. Bhatia reported that Veteran Affairs has adopted the Recovery Model. There is plan for Mental Health and Substance Abuse to jointly have a picnic and concert event.

Review Updated Division Responses to Committee Recommendations – Vicki Maca
Attachment B
Ms. Maca briefly stated the Strategic Planning is considering funding a nationally recognized person to do the strategic planning. The lead on the Strategic Planning has not been decided.

SACSAS wrote letter to Justice Behavioral Health Committee regarding the *Provisional Criminal Justice Substance Use Disorders Standards of Practice*. There are concerns over their use, implementation and potential to create unnecessary regulations. The letter was sent requesting to be kept involved on active dialogue prior to full endorsement.

Substance Abuse Core Education Contract – Nancy Heller
Attachment C
Ms. Heller stated the signed contract with Lincoln Medical Education Partnership is for one year with the option to renew. Handout addresses the funding, time periods and courses to be offered. Video Conferencing of classes may be possible but some logistics issues need to be researched.

Provisional Criminal Justice & Substance Use Disorders Standards of Practice form the JBHC- Jim Harvey
Mr. Harvey stated the discussions have begun with Probation Department to coordinate what they do and what DBH does. This is the beginning of on going discussions. Scot Adams is now the chair of the Community Correction Council. One barrier is the shortage of staff to take on the whole job of Child Behavior health.
Comments:

- There are good resources with Probation such as Ellen Brokosky and Deb Minardi.
- Will the Diversion and Drug Court programs be included?
- The Judicial branch has the infrastructure to reach judges and train judges.
- Probation is the fiscal agent for a pool of money.
- Drug courts can also tap into those funds.
- Does this incorporate children's services? Yes, through Children and Family services.
- Barriers exist due to not knowing the systems of CFS and DBH.
- The hope is to hire someone with understanding of both systems to integrate the systems.
- DBH needs information from Scott Carlson, Administrator regarding Sarpy County Drug Court and report back to the committee.
- Could there be funding available for Drug Court teams?
- Are providers of Drug Courts mandated to be at Drug Court team meetings?

Statewide Quality Improvement Team – Sheri Dawson
Ms. Dawson stated the first team meeting was August 7, 2009 via Video Conferencing and it was very successful. The final recommendation list will be received from SQIT on September 28th. Some of the recommendations are:

- Consumer Survey- how well services are going – how can we do a better job?
- Looking at the process and regulations of Co-Occurring disorders. Take a lead on a statewide level.
- Achieve our goal of having 50% consumers and 50% regular representatives.
- Consumer satisfaction to access services, services making a positive impact on consumer's lives.
- Co-Occurring planning include consumer and family involvement.

DBH will commit statewide to 2 performance measures 1) accessing services and 2) are we making a difference in lives of consumers we are serving.

Comments:

- There are a variety of survey processes that folks use.
- Quality of life scale.
- Are consumers going to fill out the surveys?
- Some consumers need assistance with surveys. Languages skill deteriorates over the years.
- Measure outcomes of SA disorder, is the client coming back?

- A Co-Occurring workgroup will present information at the February 2, 2010 meeting.
- Longer duration of commitment with care provider, better outcome.
- Outpatient level of care happens within 30day. There is a need to work with Magellan to pin down episode of care to see how often people are engaging.

Ms. Dawson will report updates at the February 2, 2010 and May 6, 2010 committee meetings.

Substance Abuse Prevention Treatment Block Grant Draft Review - Jim Harvey
Attachment D
Mr. Harvey explained the draft of the Substance Abuse Block Grant has core requirements. The Division needs to respond to 17 goals in 3 categories: 1) intended use, 2) progressive and 3) compliance. In the September 28, 2007 report Nebraska did not get a good report and Federal Government almost withheld funds. The Division reorganized to focus on what was needed to have a successful application. People were trained statewide on very particular details in the three categories. DBH is using SOMMS data, structure the data system, a priority service system and addressed prevention activities. The DBH has now received positive feedback.

Oxford Loans – Jim Harvey
Goal# 7 is related to housing approaches across BH systems. For the February 2, 2010 meeting, Committee members are asked to bring back discussion questions such as, what are the plans, what do we want to be doing, how are they structured.

- Suggestion was to invite Kirstin Hallberg to the Feb 2, 2010 meeting.
- There needs to be strong Christian based recovery model.

Wait List/Interim Services - Nancy Heller – Sheri Dawson
Attachment E
DBH has met with the Statewide Operation Teams. October 5, 2009 a new process is to roll out for folks providing SA Capacity. There will be weekly capacity and wait list report. We had to be data driven in our decisions and we added an additional position to the QI data team, Rachel West. DBH is looking at data by service, by provider, and total agency capacity, regarding what we do and don't purchase. Funding needs to be increased in priority areas and determine how to decrease funds in other areas.

DBH will be sending out a flyer to all Region providers on training being offered on MRO services. The information will give CFS all the information they need to know, and to understand our system to access our system, services and determine if a client is a priority population.

Continue SAPT Grant Draft Review - Jim Harvey
Comments:

- Use internal bridge services for folks waiting so they don't fall through the cracks. Tele-Health.
- Use interim capacity services
- Region1 does provide Tele-Health Med Management. APRN conducts Med check, LMHP or some staff sits with client.
- Waiting list – documentation requirement to make contact and documentation of interim services.
- Community Care Health Technology (CCHT), gives a gadget to patients, method for SA based usage and mood. Also can measure blood pressure, blood sugar for the day and prevent suicide.
- Focus on risk population.
- Suicide is a big concern with war veterans.
- Suggestion was to call David Tuttle in Omaha, Suicide Prevention Coordinator, for help to coordinate the LB603 helpline and the suicide line.
- Request for the next meeting- a summary of the suicide prevention grant to include amount of dollars and how many years.
- Gaps need to be addressed such as; what is being done now, what the gaps are and how gaps are going to be addressed.
- Add available Levels of Care even though they are not be funded.
- Encourage patient to use community resources.
- Prevention as part of a service because trying to prevent means sometimes you can't treat.

- SABG attempts to draw a line. No one under prevention is supposed to get treatment.
- Recovery oriented systems/relapse prevention in Goal 1.
- No adult focus in Goal 2, Primary Prevention.
- Goal 2 - develop a section on adult prevention component.
- Need to see risk and protective factor survey be continued – wants BH to support.
- Have Regions continue training regarding interim services and priority populations.
- State needs to figure out how to take down some high intensity, high cost prevention and out patient services to keep kids at home.
- State needs to decide what are the best practices to get best outcome for the dollar and fund those services.
- Goal 11, LB603-The Governor has authorized eight more resident to UNMC for training and funding for education.
- Goal 12, There are many pathways of recovery language being used by SAMHSA. Mr. Corey Brockway will summarize in a paragraph and send to Jim Harvey.
- Goal 13 – What have we done regarding the needs assessment? The report doesn't show some information because the Feds. just want a summary.
- Regarding needs assessment, Jim Harvey has asked Kate Speck to draw a link between form 8 and form 9. Suggestion is to look at Ms. Speck's findings and see where some of the gaps are.
- The outcomes are not different between voluntary or involuntary. There's a need for a change in legislature and it was suggested this be an agenda item for the future.
- Research of program evaluations and improvement are important and some funding should go into that.
- The Adult system has been strengthened. Funds need to be applied here to avoid folks needing long term treatment/services.
- Consumer Survey- the consumers don't remember giving permission to have someone randomly call them to ask them question. Magellan needs to get permission up front, respect the patient's autonomy.
- BH needs to address the gaps in treatment and prevention.
- Region 1 doesn't get a NABHO report on the peer review program.
- The Independent Peer review should be part of performance measure of the NABHO contract.

Agenda Item for Next Meeting:
Kate Speck – look at findings, may help determine gaps
Sheri Dawson – Update on Co-Occurring workgroup
Suicide Prevention Grant update
Oxford House Loan program - Kristin Hallberg
DBH to get info Drug Court

Recommendation to the Division
None noted other than suggested changes to the Substance Abuse Block Grant.

Meeting Evaluation and Suggestions
None noted

Adjournment & Next Meeting

The next meeting date is **Tuesday, February 2, 2010** at Country Inn and Suites.

Motion was made by Laura Richards and seconded by Randy See to adjourn the meeting. Voice vote was unanimous. Motion passed. Meeting was adjourned at 3:12 pm
Meeting dates for 2010 are:
February 2, 2010; May 6, 2010; September 21, 2010, December 7, 2010

Prepared by: Alexandra Castillo, Staff Assistant

Approved by _____ Date 1/14/10
Federal Resource Manager
Division of Behavioral Health

2-9-10 AC

Attachment A

State Advisory Committee on Substance Abuse Services (SACSAS)
September 17, 2009
Future Meeting Dates

2010

February 2, 2010 (1st Tuesday)

May 6, 2010 (1st Thursday)*

September 21, 2010 (3rd Tuesday)

December 7, 2010 (1st Tuesday)

*** Joint meeting of the State Advisory Committee on Substance Abuse Services and the State Advisory Committee on Mental Health Services**

Attachment B

Nebraska Department of Health and Human Services
Division of Behavioral Health
State of Nebraska
Dave Heineman, Governor

September 17, 2009

To: Ann Ebsen, Chair
State Advisory Committee on Substance Abuse Services

From: Scot L. Adams, Ph.D., Director, Division of Behavioral Health

Re: Division of Behavioral Health Responses to State Advisory Committee on Substance Abuse Services Questions and Comments

Based on the minutes of the meeting from July 14, 2009 the following Committee questions and comments were identified. The Division of Behavioral Health responses were reviewed at the State Advisory Committee on Substance Abuse Services on September 17, 2009.

The Committee Asked
At the State Advisory Committee on Substance Abuse Services meeting July 14, 2009, there was a discussion on strategic planning.

Division of Behavioral Health Response
- The Division of Behavioral Health has been preparing for a strategic planning effort.
- As a result of a very generous offer from the private sector, the Administration is considering additional options for a statewide strategic planning effort.

The Committee Asked
At the State Advisory Committee on Substance Abuse Services meeting July 14, 2009, there was a discussion on the Justice Behavioral Health Committee's *Provisional Criminal Justice Substance Use Disorders Standards of Practice*. The Committee's recommendation was approved by roll call vote:

The SACSAS embraces these principles with interest but we have concerns over their use, implementation and potential to create unnecessary regulation. We ask to be kept involved in the active dialogue on this evolving topic prior to full endorsement.

Division of Behavioral Health Response
- Ann Ebsen wrote a letter to the Justice Behavioral Health Committee (JBHC), informing them of the SACSAS recommendation.

Thanks for your work!

Attachment C

State Advisory Committee on Substance Abuse Services
September 17, 2009
Update on Substance Abuse Counselor Education Services Contract

1. The FY10 Substance Abuse Counselor Education Contract between Behavioral Health and Lincoln Medical Education Partnership (LMEP) was signed by Scot Adams, DHHS Division of Behavioral Health Director, on August 24, 2009 and by LMEP President, Dr. Alan Linderman, on September 4, 2009.

2. The Contract is effective September 1, 2009 through June 30, 2010. The option to renew for up to five (5) one-year contracts is available, if both parties agree.

3. The total funds for the FY10 Contract is $150,000, and includes courses for Core Education, Continuing Education, ASI/CASI, and Criminogenics. Some courses will be presented via video conferencing, when feasible.

4. LMEP/TAP will provide a total of **645 hours** of core education courses. A minimum of one core education course will be offered each month. These courses will be offered statewide, and LMEP/TAP will determine where to offer the courses based on participant need. Core education courses will not be offered through video conferencing.

5. LMEP/TAP will provide a total of **66 hours** of continuing education courses. The focus of these courses will be alcohol/drug specific, unless otherwise approved by DHHS. Specific courses will be developed according to, but not limited to, the following topic areas, and will be offered once during the contract period:

   Gender and Cultural Competence
   Screening and Referral
   Co-Occurring Disorders
   Evidence-Based Treatment
   Trauma-Informed

To the extent possible, criminal justice topics will be included in these continuing education courses.

6. LMEP/TAP will provide the course, Core Functions of Licensed Alcohol and Drug Counselors, two (2) times during the contract period for a total of **12 hours** of continuing education.

7. LMEP/TAP will provide the course, Examination Preparation, two (2) times during the contract period for a total of **12 hours** of continuing education.

8. LMEP/TAP will provide the course, Clinical Supervision of Licensed Alcohol and Drug Counselors, one (1) time during the contract period for a total of **6 hours** of continuing education.

9. In addition, LMEP/TAP will provide the following continuing education courses during the contract period:

   a. **up to 100 hours** of Addictions Severity Index (ASI) continuing education courses during the contract period.
   b. **up to 80 hours** of Comprehensive Adolescent Severity Inventory (CASI) continuing education courses during the contract period.
   c. **36 hours** of Criminogenics and Criminal Thinking/Behaviors as applied to Substance Abuse Treatment continuing education courses during the contract period.

10. **Other Education Initiatives and Topics**

    a. LMEP/TAP will develop additional continuing education courses, and/or incorporate additional initiatives and topics into other applicable coursework, as necessary.

For more information, please contact:

Nancy Heller, Program Specialist
DHHS-Division of Behavioral Health
PO Box 95026
Lincoln, NE 68509-5026
402-471-7823

ATTACHMENT D

This contains the meeting handouts for SAPT Review.

For the Full Complete SAPT Block Grant
Click on the attached filed provided in the E-mail along with the 9/17/09 minutes.

Form 7a Treatment Utilization Matrix

Substance Abuse Services Funded by the Division of Behavioral Health in SFY2008

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification/Hospital		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	6,429	4,363
Rehabilitation/Residential		
3. Hospital Inpatient	259	149
4. Short-term (up to 30 days)	1,590	999
5. Long-term (over 30 days)	1,156	328
Ambulatory (Outpatient)		
6. Outpatient	13,872	9,951
7. Intensive Outpatient	1,851	1,287
8. Detoxification	0	0
9. Opioid Replacement Therapy	300	280

Footnote: In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

Source: Division of Behavioral Health (September 2009)

Unduplicated Count of Persons Served in SFY 2008 in Substance Abuse Programs Funded by the Division of Behavioral Health (N=21,395)

(This includes clients who received only substance abuse services and clients who received mental health and substance abuse services.)

	Total	White		Black/African American		Native Hawaiian/Other Pacific Islander	
		Male	Female	Male	Female	Male	Female
[illegible]	606	239	141	39	13	0	0
[illegible]	5,137	2,531	1,256	163	62	7	2
[illegible]	11,401	4,993	2,920	617	265	7	5
[illegible]	4,613	2,166	1,085	384	124	4	3
[illegible]	166	96	34	8	1	1	0
[illegible]	12	5	3	2	1	0	0
[illegible]	21,935	10,030	5,439	1,213	466	19	10
Pregnant Women	199		131		15		0

Footnote: In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

Source: Division of Behavioral Health (September 2009)

	Asian		American Indian/Alaskan Native		Multi-racial	
	Male	Female	Male	Female	Male	Female
[illegible]	1	0	16	13	5	4
[illegible]	19	12	96	58	21	8
[illegible]	50	19	315	216	16	12
[illegible]	16	0	117	68	6	1
[illegible]	0	0	5	0	1	0
[illegible]	0	0	0	0	0	0
[illegible]	86	31	549	355	49	25
Pregnant Women		1		11		1

	Unknown		Other		Race Not Available		
	Male	Female	Male	Female	Male	Female	Female-Pregnant
[illegible]	4	0	22	2	66	41	0
[illegible]	29	13	182	59	401	209	9
[illegible]	53	39	575	163	663	453	20
[illegible]	14	13	148	30	276	151	7
[illegible]	1	0	3	2	9	3	2
[illegible]	0	1	0	0	0	0	0
[illegible]	101	66	930	256	1,415	857	38
Pregnant Women		3		9		28	

September 16, 2009

	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	336	186	0	51	28	0
[illegible]	3,134	1,543	8	262	110	1
[illegible]	6,454	3,779	20	749	260	0
[illegible]	2,920	1,405	7	170	48	0
[illegible]	118	38	2	3	1	0
[illegible]	7	5	0	0	0	0
[illegible]	12,969	6,956	37	1,235	447	1
[illegible]		173			20	

	[illegible]	[illegible]
[illegible]	5	0
[illegible]	53	26
[illegible]	86	53
[illegible]	41	22
[illegible]	3	1
[illegible]	0	0
[illegible]	188	102
[illegible]		6

Form 12 Treatment Capacity Matrix

Substance Abuse Services Funded by the Division of Behavioral Health - Estimated for FY2010

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 Hour Care)		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	6,460	4,710
Rehabilitation/Residential		
3. Hospital Inpatient	185	100
4. Short-term (up to 30 days)	1,510	950
5. Long-term (over 30 days)	1,100	800
Ambulatory (Outpatient)		
6. Outpatient	11,400	8,366
7. Intensive Outpatient	1,650	1,190
8. Detoxification	0	0
9. Opioid Replacement Therapy	250	240

This form contains data covering a 24-month (October 1, 2009 - September 30, 2011) projection for the period during which the State is permitted to spend the FY 2010 block grant award.

Goal #1: The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet the needs for the services identified by the State. Describe the continuum of block grant funded treatment services available in the State.

FY2010 (Intended Use)

The DBH and the Division of Medicaid and Long Term Care have recently completed a collaborative review of each of the Substance Abuse service definitions as part of process to update DBH Chapter 203 and 204. While there is no expansion of services, the new draft service definitions are more inclusive of "trauma informed care" and "recovery" language. Tentative implementation of new service definitions is January 2010.

When:

The Regional Behavioral Health Authorities contracts with the DBH will be a two-year contract to coincide with the legislative biennium budget cycle.

Where:

The Nebraska Behavioral Health Services Act established the Regional Behavioral Health Authority. This Act assigns all 93 Nebraska counties to ne of six Behavioral Health Regions. Each RBHA is governed by a Regional Governing Board consisting of one county board member (lk9ocally elected official) from each county in the region. The Regional Administrator of the RBHA is appointed by the Regional Governing Board.

Region	Regional Office	Counties	Population (2000)	% of population
1 (Panhandle)	Scottsbluff	11	90,410	5.3%
2 (West Central)	North Platte	17	102,311	6.0%
3 (South Central)	Kearney	22	223,143	13.0%
4 (Northeast & North Central)	Norfolk	22	216,338	12.6%
5 (Southeast)	Lincoln	16	413,557	24.2%
6 (Eastern)	Omaha	5	665,454	38.9%
Totals		93	1,711,213	100.0%

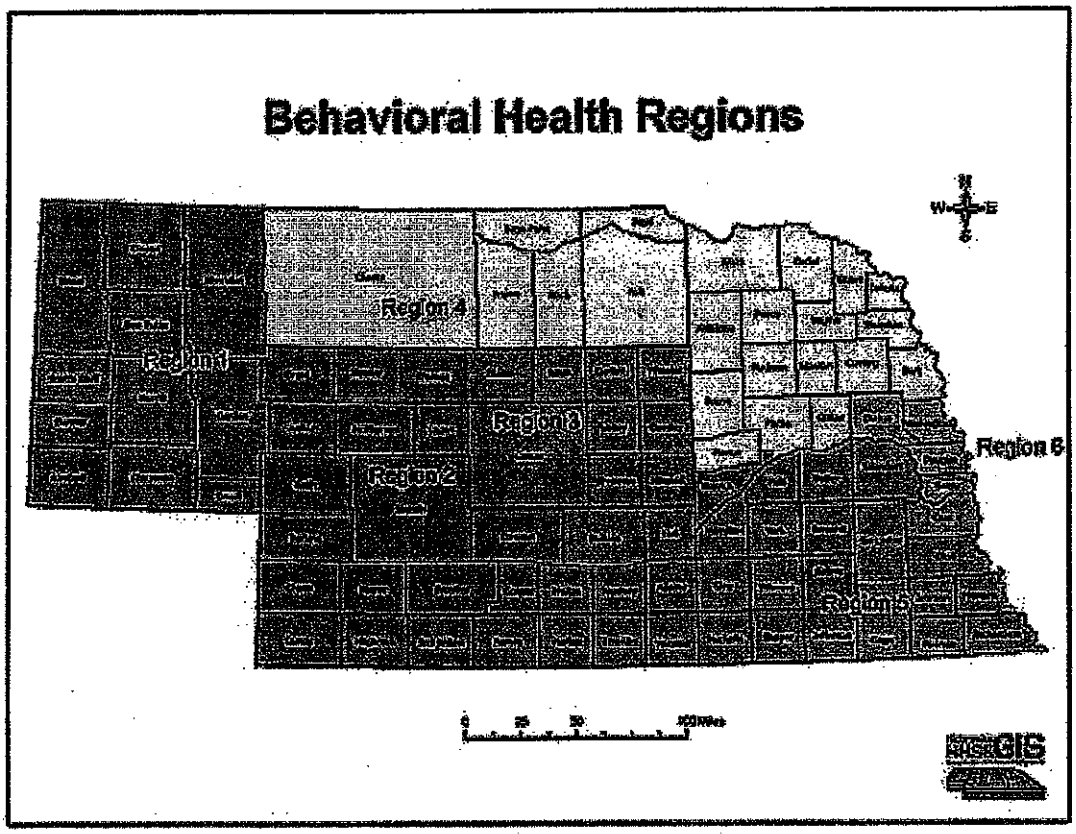
Nebraska Behavioral Health Services Act [Neb. Rev. Stat. §§ 71-801 to 71-830] establishes the framework for the provision of behavioral health services in Nebraska.
Under the Act, Rev. Stat. §§ 71-807 to 71-809 authorizes the regional administration of the Nebraska Behavioral Health System. Under §71-807, the Act assigns all 93 counties to one of six Behavioral Health Regions.

The Region's statutory and regulatory responsibilities include:

- Organize and supervise comprehensive behavioral health services,
- Ensure access to needed behavioral health services,
- Report annually to the Department of Health and Human Services regarding the expenditure of funds and the evaluation of services,
- Develop an annual regional plan based upon need and availability of resources,
- Appoint an advisory committee, and

- Consult with advisory committees on planning, organizing, contracting, program evaluation, and fiscal analysis of services in the Region.

The map below shows Nebraska Behavioral Health Regions.



How:

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community substance abuse services. Each county in a behavioral health region provides funding as match against state general funds for the operation of the behavioral health authority and for the provision of behavioral health services in the region. The Act prohibits the regions from directly providing services except under very limited circumstances. §71-809 (2) does provide exceptions. One exception is a regional behavioral health authority may continue to directly provide services it operated on July 1, 2004.

The RBHA is responsible for the development and coordination of publicly funded behavioral health services in the region pursuant to rules and regulations of the Department. The Division of Behavioral Health contracts with the RBHA to purchase services using the funds received under the Federal Substance Abuse Prevention and Treatment Block Grant.

FY 2009 (Progress)

Who:
The Division of Behavioral Health (DBH) within the Nebraska Department of Health and Human Services expends SAPT Block Grant funds in order to provide a continuum of substance abuse assessment, prevention, treatment and Detox services. The DBH utilizes a combination of Block Grant funds, state general funds, healthcare cash funds, and Medicaid funding in order to provide a statewide continuum of substance abuse services.

Target Population:
The DBH provides treatment services through contracts with the six Regional Behavioral Health Authorities (RBHA) who contract with community providers in order to serve individuals 19 years of age and older who meet the clinical and criteria for substance dependence as outlined in Diagnostic and Statistical Manual of Mental Disorders: DSM-IV. Access to treatment is prioritized giving preference to the following priority populations:

1. Pregnant Injecting IV Drug Users
2. Pregnant Substance Users
3. Injecting Drug Users
4. Women with Dependent Children

Substance Abuse services may be provided to 17 and 18 year olds through the DBH Age Waiver, when there is documentation supporting the clinical rationale for serving transition age youth in the adult service system. Requests for Age Waivers come from the Substance Abuse provider to the RBHA who, upon approval, request permission to serve from the DBH.

What:
Initial Adult Substance Abuse Assessment/Clinical Assessment and Placement

On July 1, 2009, The DBH implemented a new strategy to improve the process for priority populations to access treatment services who had not received a substance abuse assessment. Individuals from the 4 identified priority populations will now be given an appointment for an evaluation within 48 hours of their request for treatment and will receive a substance abuse evaluation within 7 business days. Based upon the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R), individuals will be referred to the appropriate level of care and receive treatment immediately. All Initial Adult Substance Abuse Assessment Reports must include the use AND results of at least one of the following nationally accepted screening instruments. The instruments may be electronically scored if indicated acceptable by author:

- SASSI (Substance Abuse Subtle Screening Inventory)
- TII (Treatment Intervention Inventory)
- SUDDS (Substance Use Disorder Diagnostic Schedule)
- MADIS (Michigan Alcohol Drug Inventory Screen)
- MAST (Michigan Alcoholism Screening Test)
- MINI (Mini International Neuropsychiatric Interview)
- WPI (Western Personality Interview)
- PBI (Problem Behavior Inventory)
- RAATE (Recovery Attitude and Treatment Evaluator)
- CIWA (Clinical Institute Withdrawal Assessment)

The **ASI (Addiction Severity Index)** is required to be used as a face-to-face structured interview guide, to be scored and utilized to provide information for the biopsychosocial assessment/substance abuse evaluation and the multidimensional risk profile.

In order to implement this, the Nebraska Department of Health and Human Services has a book of service definitions that are jointly used between the Division of Behavioral Health and the Division of Medicaid and Long Term Care. This book includes Adult Substance Abuse System definitions based on American Society of Addiction Medicine (ASAM), and are used as Patient Placement Criteria. Below is an example from this book.

Comprehensive Biopsychosocial Assessment/Substance Abuse Evaluation:

The ASI (Addiction Severity Index) is required to be used as a face-to-face structured interview guide, to be scored and utilized to provide information for the biopsychosocial assessment/substance abuse evaluation and the multidimensional risk profile. The biopsychosocial assessment/substance abuse evaluation will include all of the following:

DEMOGRAPHICS

1. Identify provider name, address, phone, fax, and e-mail contact information.
2. Identify client name, identifier, and other demographic information of the client that is relevant.

PRESENTING PROBLEM / CHIEF COMPLAINT

1. External leverage to seek evaluation
2. When was client first recommended to obtain an evaluation
3. Synopsis of what led client to schedule this evaluation

MEDICAL HISTORY

WORK / SCHOOL / MILITARY HISTORY

ALCOHOL & DRUG HISTORY SUMMARY

1. Frequency and amount
2. Drug & alcohol of choice
3. History of all substance use/misuse/abuse
4. Use patterns
5. Consequences of use (physiological, legal, interpersonal, familial, vocational, etc.)
6. Periods of abstinence - when and why
7. Tolerance level
8. Withdrawal history and potential
9. Influence of living situation on use
10. Other addictive behaviors (e.g. problem gambling)
11. IV drug use
12. Prior SA evaluations and findings
13. Prior SA treatment
14. Client's family chemical use history

LEGAL HISTORY *(Information from Criminal Justice System)*

1. Criminal history & other information
2. Drug testing results
3. Simple Screening Instrument Results
4. Risk Assessment Reporting Format for Substance Abusing Offenders Results

Behavioral Health (MH/SA) – ASAM Levels of Care and Patient Placement Criteria
Approved by the Policy Cabinet 12/17/2005 FOR DIVISIONS: BEHAVIORAL HEALTH, MEDICAID
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FAMILY / SOCIAL / PEER HISTORY

PSYCHIATRIC / BEHAVIORAL HISTORY

1. Previous mental health diagnoses
2. Prior mental health treatment

COLLATERAL INFORMATION *(Family / Friends / Criminal Justice)*

1. Report any information about the client's use history, pattern, and/or consequences learned from other sources.

OTHER DIAGNOSTIC / SCREENING TOOLS—SCORE & RESULTS

CLINICAL IMPRESSIONS

1. Summary of evaluation

a. Behavior during evaluation (agitated, mood, cooperation)
b. Motivation to change
c. Level of denial or defensiveness
d. Personal agenda
e. Discrepancies of information provided

2. Diagnostic impression (including justification) (may include DSM Axis IV)
3. Strengths Identified (client and family)
4. Problems Identified

RECOMMENDATIONS

1. Complete III. Multidimensional Risk Profile
2. Complete the ASAM Clinical Assessment and Placement Summary
   - A comprehensive biopsychosocial assessment can only be obtained through collateral contacts with significant others or family members to gather relevant information about individual and family functioning and through collateral contacts with former and current healthcare providers, friends, and court contacts to verify medical history, substance usage, and legal history.
   - When dually credentialed clinicians are completing the evaluation, the recommendations must include co-occurring issues based on the DSM IV diagnosis.
   - When LADCs are completing the evaluation, they must include a screening for possible co-occurrence of mental health problems and include referral for mental health evaluation, if appropriate, in their recommendations.

The following service categories are based on the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R).

Level I: Outpatient (Individual, Family, Group and Community Support)
Outpatient Treatment services are services which may be delivered in any appropriate community setting that is licensed in Nebraska as a Substance Abuse Treatment Center. While the services follow a defined set of policies and procedures or clinical protocols, they must be tailored to each patient's individual level of clinical severity and must be designed to help the patient achieve changes in his or her alcohol or other drug using behaviors. Individual Therapy, Group Therapy, Family Therapy and Community Support all meet the criteria defined for Level I Outpatient.

Level II.1: Intensive Outpatient
Intensive Outpatient services may be delivered in any appropriate community setting that meets state licensure requirements in Nebraska as a Substance Abuse Treatment Center. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs.

Level II.5: Partial Hospitalization (Partial Care)
The Division of Behavioral Health identifies Partial Care as the treatment modality meeting the requirements of Level II.5 Partial Hospitalization services may be delivered in an appropriately licensed Nebraska Substance Abuse Treatment Center in a community setting such as a mental health center, substance abuse center or hospital setting. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. Partial Hospitalization provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional

outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care, and can provide essential education and treatment services while allowing patients to apply their newly acquired skills in "real world" environments.

Level III.1: Clinically Managed Low Intensity Residential (Halfway House)
The current treatment modality within Level III.1 is Halfway House. The Halfway House programs for adult substance abuse provide transitional residential services for adults seeking to re-integrate into the community. These programs must provide a structured set of activities designed to develop the living skills necessary for an independent life free from substance abuse ousted of a primary residential treatment program. The program must also focus on assisting clients to maintain or access employment as needed.

Level III.3: Clinically Managed Medium Intensity Residential (Intermediate Residential, Therapeutic Community)
There are currently two service definitions that meet the definition of Level III.3 Intermediate Residential and Therapeutic Community both provide long term comprehensive residential treatment for substance abusing adults for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of the substance abuse on the individual's life or because of a history of repeated treatment failures. These programs must provide psychosocial skill building through a longer-term set of treatment activities with the expectation of a slower progress toward individual change and rehabilitation than is achieved with short-term treatment modalities. Intermediate Residential programs are typically more supportive than therapeutic communities, and rely less on peer dynamics in their treatment approach. Such services are provided through a longer term set of treatment activities with the expectation of a slower progress toward individual change. Therapeutic Community programs provide psychosocial skill building through a long term, highly structured set of peer oriented treatment activities which define progress toward individual change and rehabilitation. Client progress is marked by advancement toward accepting personal responsibility.

Level III.5: Clinically Managed High Intensity Residential (Short Term Residential, Dual Disorder Residential – III.5 Enhanced)
Services currently available within Level III.5 are Short Term Residential Treatment and Dual Disorder Treatment. The Dual Disorder Treatment is a Dual Diagnosis Enhanced Program. Short Term Residential Treatment provides highly structured 24-hour comprehensive services for substance abusing individuals who require a more restrictive treatment environment to prevent the use of abused substances. Activities of this program must provide a daily structure to prevent access to abused substances must focus on developing knowledge and skills for making lifestyle changes necessary to achieve a life free from substance abuse. Dual Disorder Treatment is designed to serve persons with co-occurring diagnosis of serious mental illness and substance abuse. The desired outcomes of the Dual Disorder Treatment Program are to stabilize the acute symptoms and to engage the individual to participate in a longer-term program of maintenance, treatment, rehabilitation, and recovery. The individuals served in this program generally present more pervasive with inadequate support systems and have difficulty sustaining involvement with treatment. The dual disorder treatment program provides simultaneous and integrated treatment of co-occurring psychiatric and substance use disorders. This requires a staff composition of dually credentialed staff. Clinical directors must be dually credentialed (LMHP/LADAC). Counselors must be dually credentialed LMHP/LADAC, however, provisional credentialed in one of the two areas is acceptable.

Level III.7: Medically Monitored Intensive Inpatient Services
This level of care is not included in the SA continuum of services funded by the DBH.

Level II.D: Ambulatory Detoxification
This level of care is not included in the SA continuum of services funded by the DBH.

Level III.2D: Clinically Monitored Residential Detoxification (Social Detox)
Social setting emergency detoxification programs provide intervention in substance abuse emergencies on a 24 hour per day basis to individuals experiencing acute intoxication. Such programs must have the capacity to provide a safe residential setting with staff present for observation and delivery of services designed to physiologically restore the individual from an acute state of intoxication.

Level III.7D: Medically Monitored Inpatient Detoxification
This level of care is not included in the SA continuum of services funded by the DBH.

Opioid Replacement Therapy (ORT) – involves the use of methadone or buprenorphine as part of the client's treatment plan for opioid addiction. Therapies offered in ORT programs include: Individualized assessment and treatment, Medication: Assessing, prescribing, administering, reassessing and regulating dose levels appropriate to the individual; Supervising detoxification from opiates, methadone or LAAM; overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders, provided as needed; Monitored urine testing; Counseling: A range of cognitive, behavioral and other addiction-focused therapies, reflecting a variety of treatment approaches, provided to the patient on an individual, group or family basis; Case management: Case management: Case management, including medical monitoring and coordination of on- and off-site treatment services, provided as needed. Case managers also assure the provision of, or referral to, educational and vocational counseling, treatment of psychiatric illness, child care, parenting skills development, primary health care and other adjunct services, as needed; Psycho education, including HIV/AIDS and other health education services.

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2010 (Intended Use): (State participation is OPTIONAL)

(1) **Who** will be served – describe the target population and provide an estimate of the number of persons to be served in the target population;

** In Fiscal Year 2010, Nebraska had outstanding 15 Recovery Home loans. Those 15 loans supported 97 beds. People who occupied these beds were at a minimum people who must be in recovery from alcoholism and/or drug addiction. The traditional method of arriving at a recovery home is toward the end of their treatment regiment which might include a 30 day inpatient facility, halfway house stay and finally recovery home. After a stay in the recovery home individuals are ready for independent living. The number of individuals occupying the 100 or so beds is not known as the State does not request registration of individuals into the house. As part of the model of self run self supporting recovery homes a recovering individual must complete a application for membership and be interviewed by the residents of the house he or she want to live in. The decision of the house residents is final.

(2) **What** activities/services will be provided, expanded, or enhanced – this may include activities/services by treatment modality or prevention strategy;

** Self supporting, self run Recovery Homes for substance abusers. The houses are residential location for individuals in recovery. No treatment or prevention services are offered in the house. Houses do have meetings, and all residents of the house are "in recovery." Operational rules of the houses include:

- The use of alcohol or drugs on the premises is prohibited.
- Residents violating use prohibition are expelled.
- Costs of the housing, including fees for rent and utilities, are paid by residents.
- Residents of house, through majority vote, establish house rules.
- Residents of house, through majority vote, approve new residents.

(3) **When** will the activities/services be implemented (date) – for ongoing activities/services, include information on the progress toward meeting the goals including dates on which integral activities/services began or will begin;

** Recovery homes are continuously available in Lincoln, Omaha, and Grand Island. Funds are available for the establishment of a house in Kearney, Ne. Loan application materials are available at the state web site: http://www.dhhs.ne.gov/hew/sua/recvyexp.htm

(4) **Where** in the State (geographic area) will the activities/services be undertaken – this may include counties, districts, regions, or cities;

** As of Une 2009 Nebraska Oxford House International, Inc. operates 23 homes in Omaha, 3 in Lincoln and one Grand Island and is scheduled to open in Kearney. Beacon of light operates two homes in Omaha that are considering being transferred to the auspices of the Nebraska Oxford House International, Inc., oversight.

NEBRASKA SELF-GOVERNED RECOVERY HOME CAPACITY

Sept. 2009

OXFORD HOUSES:

CITY	MALE BEDS	TOTAL FEMALE BEDS	WOMEN W/ CHILDREN BEDS
Omaha	116	62	14
Lincoln	7	8	0
Grand Island	7	pending	0
Kearney	pending		
Hastings		pending	
North Platte	pending		
McCook	pending		

TOTAL MALE BEDS: 130
TOTAL FEMALE BEDS: 70
WOMEN W/ CHILDREN BEDS: 14
TOTAL BEDS: 200
MALE PENDING BEDS: 21
FEMALE BEDS PENDING: 14
TOTAL BEDS PENDING: 35

NON-OXFORD HOUSES:

CITY	MALE BEDS	FEMALE BEDS	WOMEN W/ CHILDREN BEDS
Omaha	23	0	0
Hastings	0	5	

TOTAL MALE BEDS: 23
TOTAL FEMALE BEDS: 5

Source: Kirstin Hallberg [khallberg21@msn.com] September 09, 2009

(5) **How** will the activities/services be operationalized – this may be through direct procurement, subcontractors or grantees, or intra-governmental agreements.

** ** Loans are provided to non-profit entities for the development of self supporting self run group homes for recovering substance abusers. Loans are provided from the Recovery Home Loan Fund established at the State. One staff member oversees the recovery home loans repayments. The chart below indicates the "loan fund" balances during FY 2009.

The Division of Behavioral Health did enter into a contract with Nebraska Oxford House International, Inc., through the Omaha Good Neighbor Foundation to Monitor Recovery Homes within Nebraska by:

1. Visiting registered Oxford Houses at least semi-annually,
2. Visiting other Recovery Home loan recipients at least quarterly.
3. Work with Recovery Home Loan recipients to:
    a. Build a recovery home based on the recovery home loan philosophy.
    b. Instruct loan recipients on loan repayment parameters.
    c. Encourage Oxford House designation of homes not so designated.
    d. Review with delinquent homes/non profit entities loan repayment requirements and, working with the Department, establish repayment options for delinquent loan recipients.

4 . Conduct quarterly meetings of recovery home loan recipients
    a. Build coordination between Oxford Homes and other Recovery Homes.
    b. Encourage loan repayments.
    c. Resolve issues of house coordination and peer support.

5. Establish additional recovery homes.
    a. Recruit additional locations within Nebraska.
    b. Meet with potential residents, explaining requirements of the loan and of the recovery home model.
    c. Assist in completing application materials.

6. The contractor shall attend regional behavioral health authority provider meetings at least twice to promote recovery homes during the contract period.

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2010 (Intended Use):

Who

(1) The State is to submit data which shows the incidence and prevalence in the State of drug abuse and the incidence and prevalence in the State of alcohol abuse and alcoholism.

The Division of Behavioral Health completed an assessment of the need by locality and by the State in general. This work was completed with the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) definition of the term "Behavioral health disorder" in mind. Under the Act, the term "Behavioral health disorder" means mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder [Neb. Rev. Stat. §71-804(1)].

Nationally, the number of persons with substance dependence or abuse was stable between 2002 and 2007 (22.0 million in 2002, 21.6 million in 2003, 22.5 million in 2004, 22.2 million in 2005, 22.6 million in 2006, and 22.3 million in 2007).

Source: Figure 7.1 Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2007

Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008). *Results from the 2007 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm#1.2 g Persons Aged 12 or Older: 2002-2007

In Nebraska, as reported under Form 8 (Treatment Needs Assessment Summary Matrix), the Division of Behavioral Health shows the incidence and prevalence in the State of drug abuse, alcohol abuse and alcoholism. This is summarized below under the column 3. Total Population In Need.

Region	1. Substate planning area	2. Total population	3. Total Population In Need	
		Census data (estimated 2008)	A. Needing treatment services	B. That would seek treatment
1	Panhandle	85,813	7,723	494
2	Southwest	99,148	8,923	571
3	South Central	223,379	20,104	1,287
4	North East	204,799	18,432	1,180
5	South East	436,512	39,286	2,514
6	Omaha Metro	733,781	66,040	4,227
	State Total	1,783,432	160,509	10,273

Number of persons to be served

The estimated 2008 population for the State of Nebraska is 1,783,432. The National Survey on Drug Use and Health (NSDUH) data estimated 9.0 percent of the population aged 12 or older needed treatment services. Using 2008 estimated Nebraska census data, that means 160,509 people

need treatment. Within this group, NSDUH estimated 93.6% did not feel they needed treatment. Based on that number, it suggests 6.4% would seek treatment, suggesting 10,273 would do so. For more details, see forms 8 & 9.

(2) The State shall provide a description on current substance abuse prevention and treatment activities

Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) establishes the framework for the provision of behavioral health services in Nebraska. For example, § 71-806 (1) designates the Division of Behavioral Health as the Chief Behavioral Health Authority for the State of Nebraska. The primary role involves State administration and management of non-Medicaid public behavioral health services through Regional Behavioral Health Authority and direct service contracts. In that capacity, the Division provides a state leadership role as the Single State Authority.

The Nebraska Behavioral Health Services Act established the Regional Behavioral Health Authority (RBHA). Under §71-807, the Act assigns all 93 counties to one of six Behavioral Health Regions. Each RBHA is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the region. The administrator of the RBHA is appointed by the Regional Governing Board.

Region	Regional Office	Counties	Population (2000)	% of population
1 (Panhandle)	Scottsbluff	11	90,410	5.3%
2 (West Central)	North Platte	17	102,311	6.0%
3 (South Central)	Kearney	22	223,143	13.0%
4 (Northeast & North Central)	Norfolk	22	216,338	12.6%
5 (Southeast)	Lincoln	16	413,557	24.2%
6 (Eastern)	Omaha	5	665,454	38.9%
Totals		93	1,711,213	100.0%

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community substance abuse services. Each county in a behavioral health region provides funding as match against state general funds for the operation of the behavioral health authority and for the provision of behavioral health services in the region. The Act prohibits the regions from directly providing services except under very limited circumstances. §71-809 (2) does provide exceptions. One exception is a regional behavioral health authority may continue to directly provide services it operated on July 1, 2004.

What

The RBHA is responsible for the development and coordination of publicly funded behavioral health services in the region pursuant to rules and regulations of the Department. The Division of Behavioral Health contracts with the RBHA to purchase services using the funds received under the Federal Substance Abuse Prevention and Treatment Block Grant.

Under Form 7b (Number of persons served for alcohol and other drug use in state funded services) for FY 2009 there were 19,949 Unduplicated Count of Persons Served in Substance Abuse Programs Funded by the Division of Behavioral Health. This includes clients who received only substance abuse services and clients who received mental health and substance abuse services.

Current Substance Abuse Treatment Activities

Target Population:
The DBH provides treatment services through contracts with the six Regional Behavioral Health Authorities (RBHA) who contract with community providers in order to serve individuals who meet the clinical and criteria for substance dependence as outlined in Diagnostic and Statistical Manual of Mental Disorders: DSM-IV.

Access to treatment is prioritized giving preference to the following priority populations:

1. Pregnant Injecting IV Drug Users
2. Pregnant Substance Users
3. Injecting Drug Users
4. Women with Dependent Children

Initial Adult Substance Abuse Assessment/Clinical Assessment and Placement
On July 1, 2009, The DBH implemented a new strategy to improve the process for priority populations to access treatment services who had not received a substance abuse assessment. Individuals from the 4 identified priority populations will now be given an appointment for an evaluation within 48 hours of their request for treatment and will receive a substance abuse evaluation within 7 business days. Based upon the Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAP PPC-2R), individuals will be referred to the appropriate level of care and receive treatment immediately. All Initial Adult Substance Abuse Assessment Reports must include the use AND results of at least one of the following nationally accepted screening instruments. The instruments may be electronically scored if indicated acceptable by author:

- SASSI (Substance Abuse Subtle Screening Inventory)
- TII (Treatment Intervention Inventory)
- SUDDS (Substance Use Disorder Diagnostic Schedule)
- MADIS (Michigan Alcohol Drug Inventory Screen)
- MAST (Michigan Alcoholism Screening Test)
- MINI (Mini International Neuropsychiatric Interview)
- WPI (Western Personality Interview)
- PBI (Problem Behavior Inventory)
- RAATE (Recovery Attitude and Treatment Evaluator)
- CIWA (Clinical Institute Withdrawal Assessment)

The **ASI (Addiction Severity Index)** is required to be used as a face-to-face structured interview guide, to be scored and utilized to provide information for the biopsychosocial assessment/substance abuse evaluation and the multidimensional risk profile.

Level I: Outpatient (Individual, Family, Group and Community Support)
Level II.1: Intensive Outpatient
Level II.5: Partial Hospitalization (Partial Care)
Level III.1: Clinically Managed Low Intensity Residential (Halfway House)
Level III.3: Clinically Managed Medium Intensity Residential (Intermediate Residential, Therapeutic Community)
Level III.5: Clinically Managed High Intensity Residential (Short Term Residential, Dual Disorder Residential – III.5 Enhanced)
Level III.7: Medically Monitored Intensive Inpatient Services
Level II.D: Ambulatory Detoxification

Level III.2D: Clinically Monitored Residential Detoxification (Social Detox)
Level III.7D: Medically Monitored Inpatient Detoxification
Opioid Replacement Therapy - Identifies whether or not the use of methadone or buprenorphine is part of the client's treatment plan for opioid addiction.

For more details, see Goal #1: Continuum of Substance Abuse Treatment Services

Current Substance Abuse Prevention Activities

As DHHS charges ahead with a new direction for children's behavioral health, the prevention system will be interwoven as an integral component of this vision. To this end, the current activities of recent years will continue, but with a particular emphasis on strategic planning as the SPF-SIG coalitions move into implementation, as our Regional Prevention System Coordination further develops their role and as we utilize planning with our multiple system partners to identify the strengths and opportunities across the state. Attention will be paid to the Epidemiological Study, a Substance Abuse Needs Assessment, the SPF-SIG process results and other prevention partner's initiatives as well as the entire behavioral health system's structure. The result will be a more defined prevention system goal.

The Division of Behavioral Health activities include but are not limited to:

- facilitate the ongoing work of a State SYNAR/Tobacco Work Group in order to reduce the number of such illegal sales to minors.
- work with Tobacco Free Nebraska and other State Prevention System partners to develop additional strategies to promote regional and local participation in SYNAR compliance, including environmental and merchant education strategies.
- contract with the Nebraska State Patrol, local law enforcement agencies, and other appropriate substance abuse prevention entities to coordinate and/or conduct compliance checks on tobacco retailers.
- contract with Regional Behavioral Health Authorities for prevention system coordination, training and technical assistance via a Prevention Coordinator in each of the six regions.
- participate in development of the epidemiological study for the state and for the regions that identifying areas of greatest need.
- with regional Prevention Coordinators will fund training events throughout the state to introduce, enhance and improve the use of evidence based, promising and local prevention strategies; in particular to support their local community goals for the reduction of underage drinking, reduction of driving under the influence and reduction of binge drinking.
- Working with the Division of Public Health and the Division of Children and Family Services, promote a system of care that includes prevention activities. This will support the 'flip of the pyramid' with a purposeful intention of providing a more integrated and comprehensive behavioral health system of care for children, youth and adolescents.
- The Divisions of Behavioral Health and Public Health will
    - make available data for community planning designed to provide decision making support to community coalitions.
    - support the Nebraska Prevention Information Reporting System
    - provide guidance and funding in support of a statewide prevention conference that invites all prevention entities to foster networking among community coalitions, prevention professionals and agencies.
    - facilitate the implementation of the Nebraska Risk and Protective Factor Survey in FY2010.

For more information, see Goal #2 on primary prevention programs and the activities for each of the six strategies.

When

Goal 13 Intended Use covers the time starting around July 1, 2009. Almost everything the NE Division of Behavioral Health does is organized around the State Fiscal Year (July 1 to June 30), so that becomes the natural reporting cycle. If the reporting time frame is done consistently over time, then everything needed falls into place and is fully addressed. The Goal 13 Intended Use time period includes the Federal Fiscal Year of October 1, 2009 to September 30, 2010.

How

Description on current prevention and treatment activities in the State.

The Intended Use of the funds relating to prevention and treatment are reported on Form 11 as the Intended Use Plan for FY2010 .

Activity	FY10 SAPTBG	Medicaid	State Funds
Substance Abuse Prev & Treatment (non primary prev)	$5,926,439	$1,457,583	$23,039,179
Primary Prevention	1,578,586	-	183,730
Tuberculosis Serivces	-	-	-
HIV Early Intervention Services	-	-	-
Administration (excluding program/provider level)	387,903	-	-
Totals	**$7,892,928**	**$1,457,583**	**$23,222,909**

The Division of Behavioral Health contracts most of the funds to the six Regional Behavioral Health Authorities. For the FY2010 SAPTBG, Nebraska received a total of $7,892,928. These funds were allocated $5,926,439 (75%) for Substance Abuse Treatment, $1,578,586 (20%) for Primary Prevention, and 387,903 (5%) Administration (excluding program/provider level). No SAPTBG funds are used in either Tuberculosis Services or HIV Early Intervention Services.

A Description of Treatment Capacity.

Details of treatment capacity are reported on Form 6 - Substance Abuse Entity Inventory. This report includes the Entity Number, I-SATS ID, the Area Served, the State Funds allocated, the SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services allocated, a specific report of the SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children, funds for the SAPT Block Grant Funds for Primary Prevention. There are no funds allocated from the SAPT Block Grant Funds for Early Intervention Services for HIV.

Primary Prevention Activities

As noted on Form 6a Prevention Strategy Report (as of 9/2/2009), primary prevention activities include Disseminate A/V Material, Printed Material, Curricula, Newsletters and related content; Accessing services and funding; use of clearinghouse/information resources centers; community and volunteer training (such as neighborhood action training, impactor training, staff/officials training); Community drop-in centers, Community service activities, Community team-building; education programs for those who were driving while under the influence and/or driving while intoxicated; drug free dances and parties; education programs for youth groups; employee

Assistance Programs; guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use; health fairs and other health promotion, e.g., conferences, meetings, seminars; Information lines/Hot lines; media campaigns; ongoing classroom and/or small group sessions; parenting and family management; Peer leader/helper programs; Preventing Underage Sales of Tobacco and Tobacco Products per the Synar Amendment; Prevention Assessment and Referral Attendees; Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools; Recreation activities; Resources directories; Speaking engagements; Student Assistance Programs; Systematic planning; Technical Assistance Services; tobacco, and drug use policies in schools; Youth/adult leadership activities; and related activities.

The State shall provide the identities of the entities that provide the services and describe the services provided.
The Current List of substance abuse providers can be found under the Provider Table including the Inventory of Substance Abuse Treatment Services (I-SATS) ID number. That table is attached to this document. Form 6 – Substance Abuse Entity Inventory provides

- SAPT Block Grant Funds for Substance Abuse Prevention and Treatment Services
- SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children
- SAPT Block Grant Funds for Primary Prevention

The State shall submit information on **treatment utilization** to describe the type of care and the utilization according to primary diagnosis of alcohol or drug abuse, or a dual diagnosis of drug and alcohol abuse.

Form 7A - Levels of Care (Treatment Utilization Matrix)
Substance Abuse Services Funded by the Division of Behavioral Health
For treatment services provided with an initial admission to an episode of care during the 12-month State Expenditure Period of FY2008

Level of Care	A. Number of Admissions	B. Number of Persons Served
Hospital Inpatient/Residential		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	6,429	4,363
Rehabilitative/Residential		
3. Hospital Inpatient	259	149
4. Short-term (up to 30 days)	1,590	999
5. Long-term (over 30 days)	1,156	328
Ambulatory (Outpatient)		
6. Outpatient	13,872	9,951
7. Intensive Outpatient	1,851	1,287
8. Detoxification	0	0
9. Opioid Replacement Therapy	300	280

Source: Division of Behavioral Health (September 2009)
Footnote for Form 7a: In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

Opioid Replacement Therapy - Identifies whether or not the use of methadone or buprenorphine is part of the client's treatment plan for opioid addiction.

(3) The State may describe the **need for technical assistance** to carry out Block Grant activities, including activities relating to the collection of incidence and prevalence data identified in paragraph (a)(1) of this section.

- Technical Assistance on Strategic Planning. The Division of Behavioral Health completed Behavioral Health Reform by downsizing state psychiatric hospitals and moving the funds into the community. Substance Abuse was included in the effort, however, the primary emphasis was on the mental health system.
- Co-Occurring Mental Health / Substance Abuse issues – the Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in SFY2009, all clients served in mental health and/or substance abuse services was 37,669. Of this number, 19,949 (53%) were Substance Abuse ONLY Clients or Co-occurring Clients. Only 5,095 (14%) were reported as "Substance Abuse ONLY Clients". This suggests the Division of Behavioral Health needs to improve upon the services available for this population.
- Rate Setting Methods for Community Substance Abuse Services – the Division of Behavioral Health needs assistance on updating the rate setting methods used for purchasing substance abuse services in Nebraska. This rate setting method needs to take into account the issues involved in providing proper services to people with Co-occurring substance abuse and mental health problems.
- Recovery Oriented Systems of Care – part of Behavioral Health Reform included a focus on consumers of Behavioral Health services, including substance abuse. Under Neb. Rev. Stat. 71-805(1) the Office of Consumer Affairs within the Division was established. The Administrator of the Office must be a consumer or former consumer of mental health, substance abuse or gambling addiction services and must have specialized knowledge, experience or expertise relating to consumer-directed behavioral health services, delivery systems and advocacy on behalf of consumers and their families. As a result, the Division of Behavioral Health is oriented to the basic concepts of Recovery Oriented Systems of Care. However, this is an important area for improving the focus upon the substance abuse aspect of this.
- Development of a Data Strategy – the Division of Behavioral Health needs to develop a long term data strategy in order to work with the rate setting mechanism as well as a sustainable method for collecting the data needed for the National Outcome Measures.

(4) The State shall establish **goals and objectives** for improving substance abuse treatment and prevention activities and shall report activities taken in support of these goals and objectives in its application.

Goal: develop a better approach to make data driven decisions as part of the Division of Behavioral Health's Quality Improvement work:

1. Development of a National Outcome Measures (NOMs) report for the Regions and providers
2. Co-occurring Mental Illness and Substance Use Disorders – as reported above, the Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in SFY2009, only 5,095 (14%) were "Substance Abuse ONLY Clients". This suggests the Division of Behavioral Health needs to improve upon the services available for this population.

3. Consumer survey – the Division of Behavioral Health needs to review and update methods used to collect and report the consumer survey.

GOAL: Standards of Care by Episodes of Care. This is the updating and development of the appropriate standards of care. There are already service definitions. These need to be updated. In addition, the system for the Standards of Care by Episodes of Care being used by the Administrative Services Only Managed Care provider need to be improved.

Prevention Goals

1. Prevent the onset and reduce the progression of substance abuse, including underage drinking;
2. Reduce substance abuse related problems in communities; and
3. Build prevention capacities and infrastructure at the state/tribal and community levels;

The Division of Behavioral Health is committed to meeting the requirements of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). Areas of deficiency noted in the 2007 Core Technical Review will be resolved, promoting improved services and efficiency.

1. The array of substance abuse services will be based on a documented needs assessment and corresponding strategic planning.
2. The Nebraska Behavioral Health System will collect and utilize data in the planning and monitoring of substance abuse services.
3. Regional staff and providers will demonstrate knowledge of SAPTBG requirements concerning interim services. Waitlist management will occur, and interim services will be provided to priority populations. This will be documented and made easily accessible.
4. Regions will encourage and assist providers offering services to pregnant women and women with dependent children to:
   a. Become qualified as defined by federal regulation, and
   b. Demonstrate continuity of care in the consumer's written record.

Capacity and Waiting Lists

The Division of Behavioral Health is implementing an improved method for collecting and managing the capacity monitoring and waiting list. This new approach is being implemented starting on October 5, 2009. The first data reports will be received October 12, 2009. As a result, for the intended use time period, there are no data for a summary of such information for admissions / discharges or to indicate areas availability of prevention and treatment activities of insufficient capacity to meet the need. As these reports become available, there will be special attention should be provided to the following groups:

(i) Pregnant addicts;
(ii) Women who are addicted and who have dependent children;
(iii) Injecting drug addicts; and
(iv) Substance abusers infected with HIV or who have tuberculosis.

This is a description of the State's management information system pertaining to capacity and waiting lists. Under Attachment G: Capacity Management and Waiting List Systems, there is the description of how the Division of Behavioral Health is implementing the new methods. As the system is implemented, there will be documentation on when services are insufficient to meet the need and a summary of such information capacity and waiting lists. The official start of this new waiting list system is October 5, 2009. The first data will be reported to the Division of Behavioral Health on October 12, 2009. Once the data reporting starts, it will be review on the weekly

conference call with the six Regional Behavioral Health Authorities. Also, there will be monthly data reports to summarize the trends prepared by the Division of Behavioral Health.

This is part of the plan of correction efforts. In April 2009, the Division of Behavioral Health worked with the Regional Behavioral Health Authorities (RBHA) to amend the annual contract. The RBHA also amended their provider subcontracts. Contracts contained additional interim service language. Outreach activities continued to be spelled out in the contract. The contracts stated that IV-drug abusing clients shall be admitted within 14 days of request for treatment, or if no services are available, must be provided with interim services within 48 hours and admitted to treatment with 120 days. Interim services were now defined in the contract.

The RBHA and subcontractors were required to report to DBH whenever full (90%) capacity is reached and/or if an IV-drug abusing client is unable to be admitted to service.

In August 2009, a Waitlist/Capacity Management procedures and forms were approved. Training is planned for RBHA's and providers in mid-September 2009. Implementation of the new Waitlist/Capacity Management system will be October 1, 2009.

The procedures and forms specify that the individuals from the priority populations who have requested treatment, but who have not had a substance abuse assessment completed within the last 6 months, must have an appointment for a substance abuse assessment within 48 hours from time of request, and must receive the actual assessment within 7 business days of the appointment. The waitlist clock starts when a client completes the assessment process and a recommendation for treatment is made. This will ensure that individuals from the priority populations receive timely access to assessment and treatment services.

When individuals from the priority populations cannot immediately receive treatment as documented in the recommendations of the substance abuse assessment, and as outlined in the ASAM (American Society of Addiction Medicine) Patient Placement Criteria; the individual must receive Interim Services and be placed on waitlist for treatment.

The weekly SA Capacity Report and weekly SA Priority Waitlist/Interim Services Report will be completed and updated by the Behavioral Health Network Providers and be submitted to the Regional Behavioral Health Authority each week on the date established by the region. The Regional Behavioral Health Authorities will collect, analyze, and aggregate this data. Every Tuesday, the RBHA will provide the aggregated report to the Division of Behavioral Health's designated staff via email. The Division will analyze and aggregate this data in order to report on the available capacity (purchased and unpurchased) for substance abuse treatment services. The reports serve as notification to the DBH when programs reach 90 percent of its capacity and DBH will receive such reports within 7 days of reaching 90 percent capacity.

The Division will hold a weekly phone conference to direct both providers and Regional Behavioral Health Authorities to agencies across NE who has available capacity, should a specific level of care not be available in one area of the state.

Information will also be monitored via the Weekly SA Capacity Report and Weekly SA Priority Waitlist/Interim Services Report that indicate when individuals are placed on the Waitlist and when individuals are able to be removed from the Waitlist.

Regional Behavioral Health Authorities will monitor this information in order to track data regarding "length of time" individuals are waiting to access services. This data will assist our system during our annual budget planning process. The Capacity Reports will also track to ensure that all individuals who are on the Waitlist are also receiving the required Interim Services.

Note: All information provided on the Weekly SA Reports will be done so in a manner that does not identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number. The unique identifier should help DBH sort out individuals who may be duplicated among waiting lists.

Providers must maintain contact with individuals on the waitlist a minimum of every 7 days from the initial screening.

Summary Reports from the Wait List and Capacity Management Systems

As demonstrated in the table below the State of Nebraska's capacity and wait list information system is documenting the continued need for additional treatment expansion and that agencies are maintaining wait lists. Each of the Regions is experiencing wait lists with Region 5 and 6 having the largest proportion of persons waiting for services. The table below is a demonstration for selected months in the compliance and progress years showing a combination of Residential and Non-residential wait list size. Residential capacity has been steady over the time period with the distribution of additional funds from LB 1083 and emphasis by the state on the priority populations.

RESIDENTIAL

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	21	19	26	18	35	34	9
2	10	7	7	12	11	9	10
3	86	75	66	84	107	78	53
4		47		0	62	58	29
5	158	162	201	172	179	182	162
6	118	93	83	74	69	45	42
TOTALS	**393**	**403**	**383**	**360**	463	406	305

NON-RESIDENTIAL

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	5	5	5	0	0	0	0
2	0	0	0	0	0	0	0
3	73	56	55	80	38	42	41
4		66		0	21	22	31
5	209	236	261	209	210	191	173
6	176	128	213	211	204	434	349
TOTALS	**463**	**491**	**534**	**500**	473	689	594

RESIDENTIAL & NON-RESIDENTIAL COMBINED

REGION	OCTOBER 06	JANUARY 07	APRIL 07	JUNE 07	JULY 07	OCTOBER 07	JANUARY 08
1	26	24	31	18	35	34	9
2	10	7	7	12	11	9	10
3	159	131	121	164	145	120	94
4	0	113	0	0	83	80	60
5	367	398	462	381	389	373	335
6	294	221	296	285	273	479	391
TOTALS	**856**	**894**	**917**	860	936	1095	899

As demonstrated in the tables above the State of Nebraska continues to experience capacity issues as reflected in nearly 900 persons waiting to access the treatment system in January 2008. This continues to demonstrate the need for additional coordination of activities among treatment providers and the relative capabilities of the providers to address priority populations. Special emphasis has been given to priority populations, but with wait lists as extensive as those presented, last minute admissions have been the norm rather than the exception.

(6) As to prevention activities, the report shall include a description of the populations at risk of becoming substance abusers.

Based on the Form 6a Prevention Strategy Report (as of 9/2/2009) the risk populations include but are not limited to, Children of Substance Abusers, Pregnant Women/Teens, Violent and Delinquent Behavior, Mental Health Problems, Economically Disadvantaged, Physically Disabled, People Already Using Substances, Homeless and/or Run away Youth, Business and Industry, Civic Groups/Coalitions, College Students, Older Adults, Elementary School Students, Health Professionals, High School Students, Middle/Junior High School Students, Parents/Families, Preschool Students, Prevention/Treatment Professionals, Religious Groups, Teachers/Administrators/Counselors, Youth/Minors, and Law Enforcement/Military. See Form 6a Prevention Strategy Report for more details.

Attachment

Inventory of Substance Abuse Treatment Services (I-SATS) ID number

Provider Table

Provider ID	Description
100100	Mary Lanning Memorial Hospital
100103	Heartland Family Services
100118	Richard Young Hospital
100126	Catholic Charities - Columbus
100202	Good Samaritan Hospital
100278	Lutheran Family Services = Scotts Bluff
100279	Goodwill Industries of Greater Nebraska
100280	Family Services - Lincoln
100381	Omaha Tribe of Nebraska
100407	Cedars Youth Services
100415	Lincoln Medical Education Partnership
100431	Catholic Charities - Omaha
100563	Child Guidance Center
100605	North East Panhandle Substance Abuse Centre
100613	Faith Regional Health Services
100621	Prevention Pathways
100622	Women's Emp. Life Line
100662	Well Link Inc.
100779	Ponca Tribe of Nebraska
100781	BAART
100811	Region 4 Behavioral Health System
100829	Region 5 Behavioral Health System
100837	Region 6 Behavioral Health System
101041	Family Resource Council
101215	Region West Medical Center
101258	Milne Detoxification
101296	Nebraska Urban Indian Health Coalition
101298	Nebraska Urban Indian Health Coalition
101413	University of Nebraska Medical Center
101553	Great Plains Medical Center
101793	Lutheran Family Services - Omaha
300072	NOVA
300205	Panhandle Mental Health Center
301302	Behavioral Heath Specialists
301401	CenterPointe
301500	Mid Plains Center for Behavioral Health Services
301708	South Central Behavioral Health Services
750144	Central Nebraska Council on Alcohol
750151	Friendship House
750250	Cornhusker Place
750441	ARCH
750540	Santa Monica
750607	Santee Sioux Tribe of Nebraska
750904	Alegent Health Inc.
750938	Community Mental Health Center of Lancaster County
750953	Blue Valley Mental Health Center
900038	St. Monica's Behavioral Health
900305	The Bridge

900335	The Bridge
900350	Lincoln Council on Alcoholism and Drugs
900418	The Link
900491	Heartland Counseling Services
900566	Region 2 Human Services/Heartland Counseling
900699	Human Services
900731	St Francis Alcohol-Drug Treatment Center
900863	Panhandle SA Council
900921	Hastings Area Council on Alcohol
900941	Heartland Counseling Services
900962	Lutheran Family Services - Lincoln
901051	Chicano Awareness Center
901242	Houses of Hope of Nebraska Inc.
901374	Winnebago Tribe of Nebraska
NE000081	Touchstone
NE0002	Carrie A. Wolfe
NE0003	Faith Mills
NE0004	Karie Barrett
NE0005	Nebraska State Patrol
NE0006	Department of Education
NE0007	SYNAR HHSS
NE100803	Region III Behavioral Health Services
NE900707	BHS-DBA S.O.S.Place
NE900830	Pride Omaha Inc

Attachment D: Program Compliance Monitoring (See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of Title XIX, Part B, Subpart II of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2008) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:
• A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and

1. **Notification of Reaching Capacity**
   42 U.S.C. 300x-23(a) (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));
2. **Tuberculosis Services**
   42 U.S.C. 300x-24(a) (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and
3. **Treatment Services for Pregnant Women**
   42 U.S.C. 300x-27(b) (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

• A description of the problems identified and corrective actions taken:

For Notification of Reaching Capacity (one page max covering) From FY 2008 to FY2010

A description of the strategies developed by the State for monitoring compliance
The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (North East), Region 5 (South East) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

Part of the Notification of Reaching Capacity is covered under the new Wait List Management System

Attachment G: Capacity Management and Waiting List Systems provides the details on the Wait List Management System. As part of the plan of correction in April 2009, the Division of Behavioral Health to Regional Behavioral Health Authority annual contract was amended as were the RBHA to provider subcontracts. Contracts contained additional interim service language. Outreach activities continued to be spelled out in the contract. The contracts stated that IV-drug abusing clients shall be admitted within 14 days of request for treatment, or if no services are available, must be provided with interim services within 48 hours and admitted to treatment with 120 days. Interim services were now defined in the contract.

Contractors and subcontractors were required to report to DBH whenever full (90%) capacity is reached and/or if an IV-drug abusing client is unable to be admitted to service.

In August 2009, a Waitlist/Capacity Management procedures and forms were approved. Training is planned for RBHA's and providers in mid-September 2009. Implementation of the new Waitlist/Capacity Management system will be October 1, 2009.

The procedures and forms specify that the individuals from the priority populations who have requested treatment, but who have not had a substance abuse assessment completed within the last 6 months, must have an appointment for a substance abuse assessment within 48 hours from time of request, and must receive the actual assessment within 7 business days of the appointment. The waitlist clock starts when a client completes the assessment process and a recommendation for treatment is made. This will ensure that individuals from the priority populations receive timely access to assessment and treatment services.

When individuals from the priority populations cannot immediately receive treatment as documented in the recommendations of the substance abuse assessment, and as outlined in the ASAM (American Society of Addiction Medicine) Patient Placement Criteria; the individual must receive Interim Services and be placed on waitlist for treatment.

The weekly SA Capacity Report and weekly SA Priority Waitlist/Interim Services Report will be completed and updated by the Behavioral Health Network Providers and be submitted to the Regional Behavioral Health Authority each week on the date established by the region. The Regional Behavioral Health Authorities will collect, analyze, and aggregate this data. Every Tuesday, the RBHA will provide the aggregated report to the Division of Behavioral Health's designated staff via email. The Division will analyze and aggregate this data in order to report on the available capacity (purchased and unpurchased) for substance abuse treatment services. The reports serve as notification to the DBH when programs reach 90 percent of its capacity and DBH will receive such reports within 7 days of reaching 90 percent capacity.

The Division will hold a weekly phone conference to direct both providers and Regional Behavioral Health Authorities to agencies across NE who has available capacity, should a specific level of care not be available in one area of the state.

Information will also be monitored via the Weekly SA Capacity Report and Weekly SA Priority Waitlist/Interim Services Report that indicate when individuals are placed on the Waitlist and when individuals are able to be removed from the Waitlist.

Regional Behavioral Health Authorities will monitor this information in order to track data regarding "length of time" individuals are waiting to access services. This data will assist our system during our annual budget planning process. The Capacity Reports will also track to ensure that all individuals who are on the Waitlist are also receiving the required Interim Services.

Note: All information provided on the Weekly SA Reports will be done so in a manner that does not identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number. The unique identifier should help DBH sort out individuals who may be duplicated among waiting lists.

Providers must maintain contact with individuals on the waitlist a minimum of every 7 days from the initial screening.

As part of this monitoring function, there is the Audit Work Group. This group is composed of staff from the six Regions plus the Division of Behavioral Health. The group meets monthly to establish and maintain the standards used for monitoring substance abuse providers who receive funds under the Division of Behavioral Health. These standards are approved by the Division of Behavioral

Health. The expectation is that each provider is monitored once per year by the Region using these standards.

A description of the problems identified and corrective actions taken
The Region is responsible for conducting the monitoring review using the standards set by the Audit Work Group and approved by the Division of Behavioral Health. If there are problems identified during the monitoring visit, the Region requires the provider to complete a corrective action plan. Monitoring of the corrective action plan is a duty of the Region.

Tuberculosis Services From FY 2008 to FY2010
A description of the strategies developed by the State for monitoring compliance
The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (North East), Region 5 (South East) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

Requirements regarding Tuberculosis
A description of the strategies developed by the State for monitoring compliance
The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (North East), Region 5 (South East) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

As part of this monitoring function, there is the Audit Work Group. This group is composed of staff from the six Regions plus the Division of Behavioral Health. The group meets monthly to establish and maintain the standards used for monitoring substance abuse providers who receive funds under the Division of Behavioral Health. These standards are approved by the Division of Behavioral Health. The expectation is that each provider is monitored once per year by the Region using these standards.

The following matrix is a component of the Program Fidelity Audit, and includes the components reviewed by Regional Auditors regarding Tuberculosis:

Review Provider policy and procedures for TB and/or look in individual record.
16. The program reports active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and (a) adheres to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6. (b) adheres to all state and Federal confidentiality requirements when reporting such cases. (c) maintains infection control procedures that are consistent with those established by the DHHS Division of Public Health Infection Control Office.
17. The program routinely makes TB services available to each individual receiving treatment for substance abuse and monitors such service delivery. Review individual record.
18. The program has established procedures that ensures the following TB services are provided, either directly or through arrangement/agreements with other public or non-profit private entities:

(a) Screening of all admissions for TB
(b) Positive screenings shall receive test for TB
(c) Counseling related to TB
(d) Referral for appropriate medical evaluations for TB treatment
(e) Case management for obtaining any TB services
(f) Reports any active cases of TB to the DHHS Division of Public Health Tuberculosis Program
(g) Documents screening, testing and referrals and/or any necessary follow-up information

The Region is responsible for conducting the monitoring review using the standards set by the Audit Work Group and approved by the Division of Behavioral Health. If there are problems identified during the monitoring visit, the Region requires the provider to complete a corrective action plan.

Each Region then submits the results of the Program Fidelity Audit to the Division of Behavioral Health. The Division's designated Network Specialist reviews the Audit results and notes the need for any corrective action with compliance to these regulations. The Network Specialist will complete a cover sheet for the audit, which documents the receipt and review of the audit, and Documents the need for corrective action when appropriate.

Upon receipt of the corrective action plan, the Region will forward the plan to the Division. The Network Specialist at the Division reviews the plan and works with the Region to ensure the provider implements the plan to ensure compliance with the Standards.

A description of the problems identified and corrective actions taken
As the checklist above was implemented in 2009, to date, no problems have been identified by this checklist and no corrective actions have been taken.

As part of this monitoring function, there is the Audit Work Group. This group is composed of staff from the six Regions plus the Division of Behavioral Health. The group meets monthly to establish and maintain the standards used for monitoring substance abuse providers who receive funds under the Division of Behavioral Health. These standards are approved by the Division of Behavioral Health. The expectation is that each provider is monitored once per year by the Region using these standards.

A description of the problems identified and corrective actions taken
The Region is responsible for conducting the monitoring review using the standards set by the Audit Work Group and approved by the Division of Behavioral Health. If there are problems identified during the monitoring visit, the Region requires the provider to complete a corrective action plan. Monitoring of the corrective action plan is a duty of the Region.

Treatment Services for Pregnant Women (one page max covering) From FY 2008 to FY2010

A description of the strategies developed by the State for monitoring compliance
The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (Substate Planning Areas): Region 1 (Panhandle), Region 2 (Southwest), Region 3 (South Central), Region 4 (North East), Region 5 (South East) and Region 6 (Omaha Metro) per the requirements of the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§71-801 to 71-830). All of the requirements for the proper monitoring of the Substance Abuse Prevention and Treatment Block

Grant are contained within the contract between the Division of Behavioral Health and the Regional Behavioral Health Authority.

A description of the problems identified and corrective actions taken
The Region is responsible for conducting the monitoring review using the standards set by the Audit Work Group and approved by the Division of Behavioral Health. If there are problems identified during the monitoring visit, the Region requires the provider to complete a corrective action plan. Monitoring of the corrective action plan is a duty of the Region.

The state monitors the adequacy of efforts by programs funded to serve pregnant women and women with dependent children through a number of checks and balances. These methods include monthly financial reports, registration, authorizations and continued care reviews through Magellan Health data system and on-site technical assistance by Division staff, in additional to the waiting list monitoring system.

As a contractual requirement, each Region monitors the provision of services to pregnant women and women with dependent children through audits of program fidelity. *A Program Fidelity Audit is conducted by the Region for their contracted network providers, and by the Division for Regions who provide these services directly. An internal tracking system was designed to ensure that program fidelity audits were completed correctly and in a timely manner. If a corrective action plan was indicated in the program fidelity audit, the Division worked with the Region and the provider to ensure that technical assistance was provided in any area where problems were identified.

If any qualifying services were not offered as a direct service provision, the Division mandated that an affiliation agreement be in place with a local entity to ensure that access to such services were made available upon request of the consumer. All programs providing such services were encouraged to treat the family as a unit and work towards building capacity that would allow admission of both women and their children into treatment services, if appropriate.

Attachment E

Capacity and Waitlist Management System Overview

SA Capacity and Waitlist and Interim Service Provision

1. The attached Weekly SA Capacity Report and Weekly SA Priority Waitlist/Interim Services Report will be completed by the Behavioral Health Network Providers and submitted to the Regional Behavioral Health Authority each week. The week runs Monday through Sunday.
2. The RBHA will collect, analyze, and aggregate this data. Every Tuesday, the RBHA will provide the aggregated report to the Division of Behavioral Health's designated staff, Rachel West, via email.
3. The Division will analyze and aggregate this data in order to report on the available capacity (purchased and unpurchased) for substance abuse treatment services. The reports serve as notification to the DBH when programs reach 90 percent of its capacity and meet the requirement to report within 7 days of reaching 90 percent capacity.
4. At the end of the weekly Regional Center call, the Division will briefly discuss capacity and wait list issues.
5. The Capacity Reports will also track individuals who are on the Waitlist and receiving the required Interim Services.

Note: All information provided on the Weekly SA Reports will be done so in a manner that does not specifically identify the individual. A unique consumer identifier containing the first four characters of the last name + date of birth (YYYYMMDD) + the last four numbers of the social security number.

Specific instructions and definitions are provided on the attached forms.

Waiting List and Interim Services Provision Documentation

Providers must maintain contact with individuals on the waitlist a minimum of every 7 days from the initial screening.

Providers must maintain documentation of the following:

1. Client unique identifier, DOB, name, address, phone, and alternate address and phone, if applicable;
2. Date of the initial face to face screening and the recommended treatment service and date placed on the waiting list;
3. Priority category for admission;
4. Whether the client was referred to another agency, if they accepted the outside referral, the date the referral was made and the provider to which the individual was referred;
5. Whether the client was placed in interim services and what type of interim services;
6. Counselor/client follow-up (minimum every 7 days from initial screening) including date and type of contact and name of staff person;
7. Number of days before placed in recommended treatment; and
8. Date and reason for removal from the waitlist if the client was not placed into the appropriate recommended treatment.

Monitoring Interim Service Provision

(To be discussed, revised and finalized with the Statewide Audit Workgroup)

1. Regional Behavioral Health Authority Audit staff will provide monitoring of interim service documentation noted in the previous section.
2. The Interim Service Provision Audit will be utilized at the time of a Substance Abuse provider's services purchased and/or fidelity audit.
3. RBHA Audit staff will provide audit results and technical assistance to the provider and then fax or mail the checklist to their assigned DBH Field Representative.

4. DBH data team members will aggregate and analyze the audit data and present to the DBH program staff assigned to manage the treatment capacity and waitlists.
5. Aggregate data will be shared with RBHA staff and providers through the Quality Improvement structure and Tuesday morning calls to ensure ongoing improvement and compliance with federal block grant requirements.

Mental Health Treatment Capacity

1. The Division of Behavioral Health, in collaboration with the six Regional Behavioral Health Authorities, will also collect data relevant to accessing the publically funded mental health services.
2. Mental Health Capacity information will be sent to the designated DBH staff, Rachel West, on the 15th of each month.

Capacity and Waitlist Management Data Reports

The following information may be presented in monthly data reports available to providers, regions and DBH and discussed on the weekly calls and through the QI structure:

- Average wait time for admission by priority population by service by region by state;
- Total capacity by service by region by state
- Regional Purchased capacity by service by provider by region by state
- Number of individual on the wait list by priority by service by region by state
- Number of individuals receiving interim services within 48 hours
- Average length of interim services
- Number of priority population served with 14 days or by 120 days
- Number of Magellan authorized or registered interim services for individuals on the wait list by service by region by state
- Reason for removal from waitlist by service by provider by region by state